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ABSTRACT

As health education moves toward a conceptual approach to teaching health concepts, concerned educators are carefully evaluating appropriate educational models which could be used. The Instructional Programming Model (IPM), which is at the heart of Individually Guided Education (IGE), specifically takes into account each pupil's beginning level of performance, rate of progress, style of learning, motivational level, and other characteristics in the context of the education program of the school. Regardless of the specificity of the objectives and whether or not the same level of mastery is desired of every student, seven sequential steps are followed in implementing the model. These are (1) the setting of general educational objectives to be attained by the student population of a school; (2) the identification of the range of health education objectives that may be attainable for subgroups of the student population; (3) the assessment of each student's level of understanding, skill, or attitudinal development; (4) the setting of instructional health education objectives for each student in the unit; (5) the planning and implementing of an instructional program whereby the student attains selected health education objectives; (6) the assessment of students to determine their attainment of the objectives; and (7) the re-evaluation of a student who has failed to attain an objective. Also, curricular materials, whether developed for IGE or another instructional system, should be accurate and reliable, learnable by the particular students for whom they are prepared, teachable, and suitable in terms of cost, attractiveness, and the amount of inservice teacher education required. (DMT)

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by Elaine J. Anderson, Ph.D.

Introduction to IGE

Individually Guided Education (IGE) started in embryonic form when a project called Maximizing Opportunities for Development and Experimentation in Learning in the Schools was begun at the Wisconsin R & D Center under the direction of Herbert Klausmeier as principal investigator in 1964.¹

During the period from 1964 to 1966 several concerns were identified related to educational practices. Among the concerns identified were these:

1. Norm-referenced tests of intellectual ability and educational achievement were used to categorize and grade students, not to improve their instruction.
2. Children of approximately the same age were placed in graded classes and expected to attain the same instructional objectives by studying the same graded basic textbooks and supplementary materials.
3. Teachers were treated as if they were equally competent in all subject fields and in all media and methods of instruction.

¹Herbert J. Klausmeier, William L. Goodwin, John Prash and Max R. Goodson, with an Introduction by Warren G. Findley, Project Models: Maximizing Opportunities for Development and Experimentation in Learning in the Schools, (Madison: Wisconsin R & D Center, Occasional Paper No. 3, 1966).

No provisions were made for differences among teachers in interests, experience, knowledge, and competence.

4. Teachers and principals did not have enough planning time to make major changes and improvements in instruction.
5. The role of the principal as a manager and of the teacher as an independent ruler of a classroom did not facilitate the educational leadership of the principal or the creative use of teacher strengths, talents, and interests.
6. Staffing arrangements did not permit cooperative decision-making among teachers or between the teacher and the principal. Conventional organization allowed decisions to be made without important information from other sources.
7. Communication between the school and the home was through report cards, supplemented by parent-teacher conferences. Little effort was made to utilize the resources of the community in the educational program.

Individually Guided Education was developed out of considerations relative to these concerns.

Health Education and The Instructional Programming Model

As health education moves toward a conceptual approach to teaching health concepts, concerned educators are carefully evaluating appropriate educational models which could be used. Read and Greene² in their recent book entitled Creative Teaching in Health offer many ideas for

²Donald A. Read and Walter H. Greene, Creative Teaching in Health, 2nd edition (New York: Macmillan Publishing Co., Inc., 1975).

individualizing learning experiences and hence humanizing education. Blount and Klausmeier were suggesting teaching-learning units as early as 1953.³ More recently, Klausmeier refined the idea into the Instructional Programming Model (IPM)⁴ which is at the heart of IGE. It specifically takes into account each pupil's beginning level of performance, rate of progress, style of learning, motivational level, and other characteristics in the context of the educational program of the school and in this case the health concepts that have been identified by the School Health Education Study.⁵ Instructional programming for the individual student must be appropriately planned and implemented in the cognitive, psychomotor, and affective domains. It is used with explicitly stated instructional objectives and criteria of mastery which indicate that every student should attain the same level of mastery of health concepts before proceeding to the next objective, or item of a curricular sequence. It is used equally well with expressive, affective, or other objectives of instruction, that imply, for example, that not all students should engage in exactly the same number or kind of activities, or reach an identical level of achievement, interest, or motivation. Thus, the IPM is a model which suggests how objective-based instruction may proceed in various curricular areas, rather than prescribing that objective-based instruction should proceed in an identical manner in all curricular areas.

³ Nathan S. Blount and Herbert J. Klausmeier, Teaching in Secondary School, 3rd edition (New York: Harper and Row, 1953).

⁴ Herbert J. Klausmeier, Mary R. Quilling, Juanita S. Soreson, Russell S. Way, and George R. Glasrud, Individually Guided Education and the Multiunit Elementary School, Guidelines for Implementation, (Madison, Wisconsin, Research and Development Center for Cognitive Learning, 1971), p. 19.

⁵ School Health Education Study, Health Education: A Conceptual Approach to Curriculum Design (St. Paul, Minn.: 3M Education Press, 1967).

Regardless of the specificity of the objectives and whether or not the same level of mastery is desired of every student, seven sequential steps are followed in implementing the model according to Klausmeier.⁶

Step 1 is the setting of general educational objectives to be attained by the student population of a school within a period of a year or longer in terms of level of achievement or other performance related to each curricular area, in accordance with acceptable value orientations and desirable action patterns. In formulating the general health education objectives, attention is given not only to priorities, but also to the programs to be utilized and the criteria to be accepted as evidence that the objectives have been attained.

Step 2 is the identification of the range of health education objectives that may be attainable for subgroups of the student population. Some of the general health objectives, for example, are more suitable for children in upper intermediate units than for those in primary units.

Step 3 is the actual assessment of each student's level of understanding, skill, or attitudinal development, either by observing performance or by administering tests and other measures. Criterion-referenced tests are particularly useful for assessing mastery of instructional objectives in health education. When the appropriate subset of objective-related tests is administered, the deficiencies in health education concepts of each student are pinpointed, and the instructional objectives for the individual students can be identified.

⁶Herbert J. Klausmeier, Mary R. Quilling, Juanita S. Sorenson, Russel S. Way, and George R. Glasrud, OP CIT., 1971.

Step 4 is the setting of instructional health education objectives for each student in the unit to attain over a short period of time. Particular health concept understandings and skills in which the student is deficient become that student's instructional objectives.

Step 5 is the planning and implementing of an instructional program whereby the student attains selected health education objectives. The plan is implemented by varying (a) the amount of attention and guidance by the teacher, (b) the amount of time spent in interaction among students, (c) the use of printed materials, audiovisual materials and direct experience, (d) the use of space and equipment, and (e) the amount of time spent by each student in one-to-one interactions with the teacher or media, in independent study, in adult or student-led small group activities, and in adult-led large group activities.

Generally, each teacher instructs one or more groups of students who are working toward mastering the same objective or set of objectives. In each small group, materials, methods, use of time, and the like are matched to individual pupils with consideration given to their present level of skill development, rate of learning, preferred learning style, and other characteristics. Personal characteristics, such as sociability, motivation, and emotional maturity are also given attention. To the extent that staff is available, individual tutoring and goal setting conferences are provided for each student.

Step 6 is the assessment of students to determine their attainment of the health education objectives.

Step 7 is if a student has failed to attain an objective, his/her readiness to attain it must be re-evaluated, as should other parts of

the instructional programming sequence. On the other hand, if the student has attained the instructional objective, or set of objectives, he/she moves ahead to the next objective or set of objectives. In a mastery-based, sequenced health education curricular area, the desired level of mastery and the successive objectives in the sequence are predetermined and are the same for all students. Other curriculum areas may not have a fixed sequence for attaining objectives nor require all students to attain level of mastery of objectives. Figure 1 presents the IPM as adapted by the author to show how a team might utilize it in planning and implementing a school health program.

Compatible Curricular Materials

Klausmeier has indicated, curricular materials, whether developed for IGE or any other instructional system, should incorporate four main attributes.⁷ First, the health education content incorporated in the material should be accurate and reliable. For example, scholars in health education should agree that the content is free of cultural bias, factual errors, and possible misinterpretations of the information.

Second, the content should be learnable by the particular students for whom it is prepared. Here, the concerns are that the health education content items--facts, concepts, and skills--are properly paced sequentially into the curriculum and that the steps in the sequence are not so large or abrupt that the student cannot accomplish them or so small and repetitive that student curiosity and creativity give way to disinterest and distaste.

⁷ Klausmeier. "IGE: An Alternative Form of Schooling." in Harriet Talmage, Individualized Instructional Delivery Systems, Natural Society for the Study of Education (Chicago: University of Chicago Press, 1975), Chapter 4.

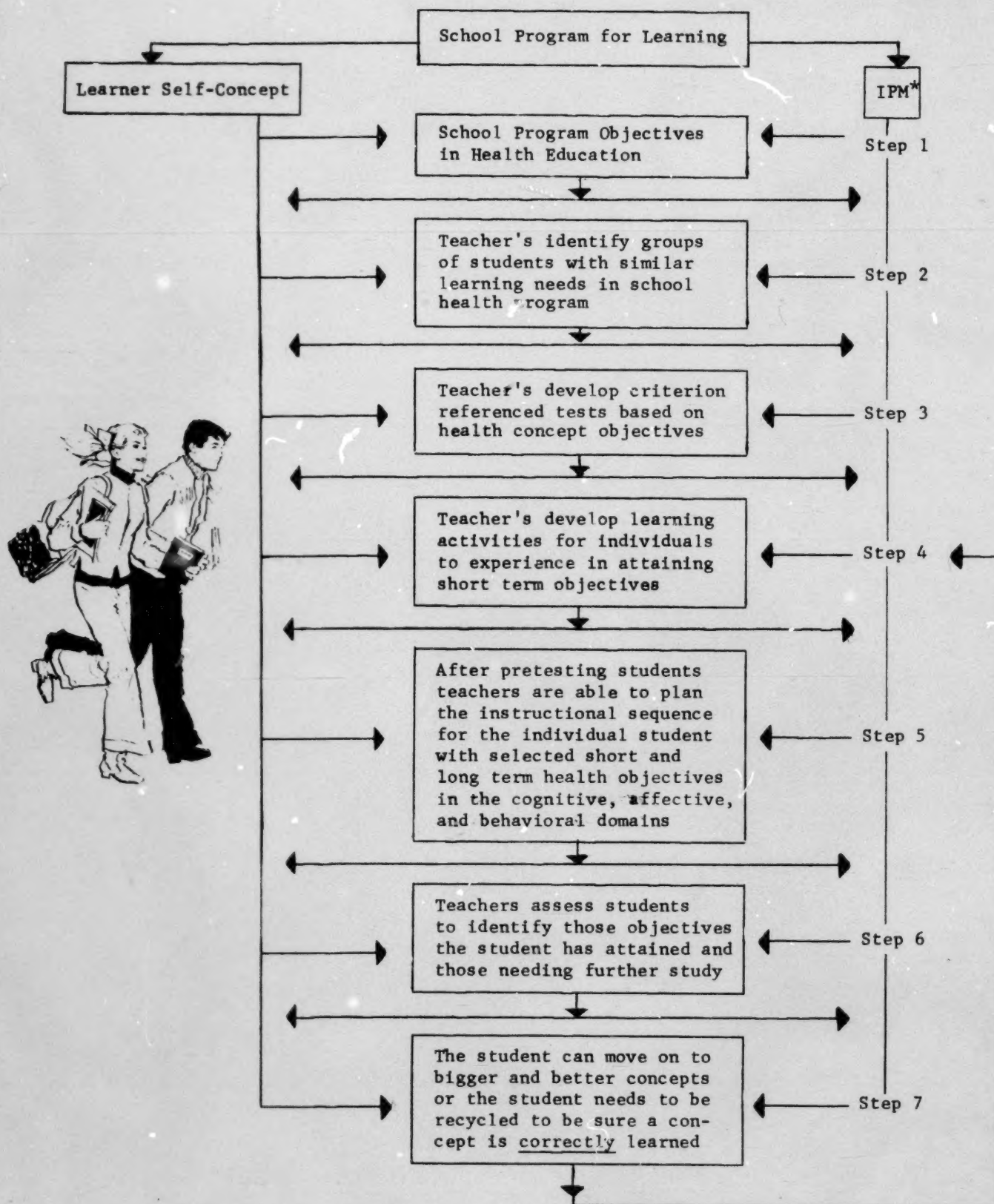


Figure 1
Learner Self-Concept and the IPM*(Adapted)

Third, the health education materials and related activities should be teachable. To be compatible with the IPM and the evaluation needed, each set of materials in any curricular area should include (a) clearly stated objectives, either behavioral or expressive; (b) assessment tools and procedures directly related to each objective that will aid teachers in the initial, formative, and summative evaluation of student learning; (c) print and non-print instructional materials that will enable students to attain each objective; and (d) suggestions to teachers concerning possible instructional activities that effectively combine the use of the materials with student and teacher activities. This last attribute of health education curricular materials assumes that each teacher, in order to attain any particular objective that may be common for students, must be able to vary the instructional activities for particular students in order to provide for individual differences.

Fourth, the materials should be suitable in terms of cost, attractiveness, and the amount of inservice teacher education required. Neither IGE nor any other form of schooling will improve education when the materials of instruction are either unattractive to children and teachers, or so costly that school districts cannot afford them. Similarly, while it is expected that new materials will require some inservice training, it is futile to incorporate new content and methodology which will require massive inservice education before it can be handled by teachers. For this reason it is important to utilize professional "in-house" talent for an ongoing school district learning experience. Some districts provide release time and monies for curriculum development that is meaningful for the local school health program.

Summary

Although IGE and its instructional programming model (IPM) are only one strategy for individualizing and humanizing education in our public schools today, it is a viable option for health educators. The health educator is concerned about the total human being in an integrated series of learning experiences. The cognitive, affective, psychomotor domains, as well as health behavior patterns are all of major importance in health education. The IPM gives health educators a way to implement a conceptual approach in health education for the individual student, while actualizing the uniquenesses of the individuals in their classrooms.

Note: For more information regarding the IGE model for change, two agencies can be contacted:

The R & D Center for Cognitive Learning
1025 W. Johnson Street
Madison, Wisconsin 53706

ATTN: R. Rossmiller

and

/I/D/E/A/
5335 Fall Hills Avenue
Dayton, Ohio 45429

ATTN: S. Sava

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